

# MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

## PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> (X) HCP ( ) IE ( ) IC	<b>Response Timely Filed?</b> (X ) Yes ( ) No
Requestor's Name and Address The San Antonio Orthopaedic Surgery Center PO Box 34533 San Antonio, Texas 78265	MDR Tracking No.: M4-04-2576-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address: Texas Mutual Insurance Company Box 54	Date of Injury:
	Employer's Name: Mission Road Developmental
	Insurance Carrier's No.: 99D0000339011

## PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
08/11/2003	08/11/2003	72275 – X-Ray	\$281.40	\$0.00

## PART III: REQUESTOR'S POSITION SUMMARY

The carrier has not provided the proper payment exception code in this instance, which is in violation of the Texas Administrative Code. Carrier did not make "fair and reasonable" reimbursement and did not make consistent reimbursements.

## PART IV: RESPONDENT'S POSITION SUMMARY

The reimbursement for the service rendered has been determined to be fair and reasonable based on billing and payment research and is in accordance with Labor Code 413.011(b). The requestor failed to prove that it's billing of usual and customary is fair and reasonable. The carrier's payment is based heavily on a Medicare based approach and it should be considered fair and reasonable for these types of services and procedures.

## PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

This dispute relates to services provided in an Ambulatory Surgical Center that are not covered under a fee guideline for this date of service. Accordingly, the reimbursement determined through this dispute resolution process must reflect a fair and reasonable rate as directed by Commission Rule 134.1. This case involves a factual dispute about what is a fair and reasonable reimbursement for the services provided.

After reviewing the documentation provided by both parties, it appears that the respondent provided persuasive information that supports that their recommended amount is fair and reasonable. It does not appear that the requestor provided convincing documentation that sufficiently discusses, demonstrates, and justifies that their purported amount is a fair and reasonable reimbursement (Rule 133.307).

Based on the documentation contained in this dispute and both parties' positions, it appears that the fair and reasonable reimbursement is the amount paid by the respondent for all services rendered on this particular date. Therefore, no additional reimbursement is due.

**PART VI: COMMISSION DECISION**

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to additional reimbursement.

Issued by:

Allen C. McDonald, Jr.

May 12, 2005

Authorized Signature

Typed Name

Date of Order

**PART VII: YOUR RIGHT TO REQUEST A HEARING**

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on 05/12/2005. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

**Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**

**PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION**

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: \_\_\_\_\_ Date: \_\_\_\_\_